TOTAL BODY REHAB
ORTHOPEDIC AND HAND THERAPY

MEDICAL HISTORY

Patient Name: _____ Date: _____

Date of Injury or Onset if Known: _____ Date of Surgery: _____

Please check the box of the conditions you have had or currently have

Systemic: Have you ever been diagnosed with HIV, AIDS, or Hepatitis?	
Cardiovascular: Do you have high or low blood pressure?	
Do you have a pacemaker or have a had chest pain/angina or other heart problems?	
Pulmonary: Do you have any respiratory problems (asthmas, COPD, emphysema, etc)?	
Neurological: Have you had a stroke, head injury, concussion or any other seizure disorder?	
Have you been diagnosed with Multiple Sclerosis, Polio, Cerebral Palsy or other condition?	
Have you experienced any loss of balance or falls?	
Musculoskeletal: Do you have any artificial joints/prosthesis?	
Do you have osteoporosis, osteopenia or any type of arthritis?	
Have you been diagnosed with Fibromyalgia, Chronic Fatigue or similar condition?	
Psychological: Do you have depression, anxiety or any other psychological diagnosis?	
Genitourinary: Are you or could you be pregnant?	
Do you have any loss of bladder control or function?	
Endocrine: Do you have diabetes?	
Skin: Are you allergic/sensitive to latex and/or tape?	
Do you or have you ever had Cancer?	
Have you had any unexplained weight loss or gain?	
Do you have night sweats, fevers or chills?	
Do you smoke cigarettes, cigars or pipes?	
Have you had any other physical/speed therapy this year?	
Have you ever had homecare services?	
Please list any medications & dosages you are taking:	
Please list any disease, condition or surgery not listed above:	

When do you return to your referring Doctor? _____ Right or Left Handed _____

<u>Reasons for attending therapy:</u>

Limited Range of Motion: _____ Weakness: _____ Other: _____

ON a scale of 1 to 10, my WORST pain during the day is a _____. The BEST it gets is a_____.

<u>TREATMENT CONSENT:</u> Your medical history has been reviewed by your TOTAL BODY REHAB Therapist to assist him in your evaluation and assessment, and they have explained your treatment, any alternatives, and possible risks with you. Any questions you may have had have been answered to your satisfaction.

Patient Signature: _____ Date: _____ Therapists' Initials: _____